Affiliated Wellness Group, LLC

Informed Consent for Esogetic Color Puncture Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of my practice regarding confidentiality for your health information. Your rights as a patient are shown below. My privacy practices are shown in a separate document provided to you.

You have a right to withdraw this informed consent, in writing, at any time.

DISCLAIMER: This service does not offer medical advice, and nothing contained in the service is intended to constitute professional advice for medical diagnosis or treatment. Advice received via this service should not be relied upon for medical, legal, or financial decisions, and you should consult with an appropriate professional for specific advice tailored to your situation. You should always seek the advice of your physician or other qualified health provider prior to starting any new treatment or with any questions you may have regarding a medical condition.

LATE CANCELLATIONS AND NO-SHOWS: Cancellations or changes must be made at least 24 hours prior to the scheduled appointment. If cancelled in fewer than 24 hours, full charges will apply. Payments for services and package plans are nonrefundable. Prepayments may be applied to other services at the discretion of the practitioner.

I have read and fully understand all terms and statements herein. I have truthfully and accurately stated all conditions that I am aware of and to the best of my ability. I will inform this provider of any changes in my status at my earliest convenience.

By my signature below, I attest that my rights have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and Grievance Procedure, and a copy of the Notice of Privacy Practices.

____
Client's Full Name (Please Print)

____ _____ / _____ / ______
Client Signature Date